CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-5722

September 28, 2005

Ivor Groves, PhD
2107 Delta Way
Tallahassee, Florida
32303

RE: *Emily Q. v. Bonta*, U.S. Dist. Ct., C.D. Cal. Case No. CV 98-4181 AHM (AJWx)

Dear Dr. Groves;

Enclosed is a copy of the Los Angeles County Mental Health Plan (MHP) Focused Review of Evaluation of Services to Emily Q. Class Members. This report reflects the findings and recommendations of the Department of Mental Health's (DMH) TBS Focused Review Team that conducted the focused review between the dates of July 25, 2005 and July 29, 2005. This report is also being sent to Plaintiffs on September 28, 2005, within the sixty-day time frame agreed to by the parties for the completion of the report.

This report is the final of five reviews that will be completed by DMH in accordance with the Court Order in the Emily Q. et al., v. Diana Bonta case, No. CV 98-4181 AHM (AJWx). Pursuant to the Order, Topic A, AGREEMENTS RE: TBS DATA AND MONITORING, Item 4, "Focused Reviews", DMH agreed " it shall perform focused reviews of mental health services provided to class members by MHPs. The focused reviews will examine quality of care and adequacy of services provided." Under this same area, Topic A, Item 5 "Protocol for Focused Reviews", DMH consulted with Plaintiffs in the development of the protocol for the focused reviews prior to commencing the reviews and incorporated the recommendations of the Special Master concerning the content and implementation of the review protocol; in addition, under Items 6, 7 and 8 of the same topic area,

DMH is now entering into a collaborative process to work with the MHP through the existing contractual arrangement and utilizing the training available through the California Institute for Mental Health (CIMH) to develop a Corrective Action Plan and plan for DMH to provide any necessary technical assistance and training. This report is a significant part of an assessment effort by DMH to provide the county with a comprehensive evaluation of TBS utilization.

Additionally, DMH intends for this report to establish a foundation for counties and DMH to work towards promoting maximal levels of appropriate TBS utilization. The development of the protocol, the process of conducting the focused reviews, the reporting methodology, and the follow-up improvement plans are consistent in addressing provisions of the court order.

Please let me know if I can be of additional assistance.

Sincerely,

RITA MCCABE, LCSW
Acting Chief DMH Medi-Cal Policy Branch

cc: Mateo Munoz
John Krause
Norm Black
Barbara Zweig
Melinda Bird

Qualitative Focused Review Report

County MHP: Los Angeles Department of Mental Health

Review Dates: July 25, 2005- July 29, 2005

Review Team Members: Troy Konarski, MSW, DMH, County Operations
Connie Lira, RN, DMH, Medi-Cal Oversight
Anne Murray, LCSW, DMH, Medi-Cal Policy & Support
Cynthia Rutledge, DMH, Medi-Cal Policy & Support
Ivor Groves, PhD, Special Master for Emily Q

I. Purpose

The overarching purpose of the Qualitative Focused Review Report is to capture, in one comprehensive document, all the evaluation efforts that have occurred, and to synthesize the relevant information that has been collected from the focused review for evaluation of services to Emily Q. class members. The following report represents a documented comprehensive assessment that will provide a foundation for supporting county Mental Health Plans (MHPs) in development of their strategic improvement efforts. County MHPs and the State Department of Mental Health (DMH) will need solid, relevant and comprehensive data and information in order to proceed with making well-informed recommendations and decisions regarding services to eligible class members and to advance potential strategic improvement initiatives to ensure appropriate access to those services.

During the focused reviews, the specific purpose of reviewing the selected counties is to quickly and comprehensively gain an informed understanding of the dynamics of Therapeutic Behavioral Services (TBS) utilization in a select group of MHPs. Only after such an evaluation can DMH and county MHPs begin to logically and intelligently strategize a collaborative set of initiatives to improve TBS utilization and outcome measures. The primary data sources used in selecting the MHPs this year included the county's number of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligibles, the TBS utilization rate, the Rate Classification Level (RCL) placement rate, the re-hospitalization rate, and the MHP's state hospitalization rate.

Review Team Comments:
In the specific case of Los Angeles Department of Mental Health (LADMH), your county was selected for TBS focused review based on the following observations: 1,251,655 *average monthly Early Periodic Screening Diagnosis and Treatment (EPSDT) eligibles; .08% penetration rate; 3.78% decrease in RCL 12-14 placement rate; 7.07% decrease in hospital readmission rate; and 4.57% decrease in the state hospitalization rate.* In addition, LADMH is the largest County Mental Health Plan the State of California. One third of the EPSDT clients

served in California are LADMH Medi-Cal beneficiaries, thus, a review of LADMH is critical in an evaluation of any component of the California Mental health system.

II. Procedure/Methods of Qualitative Focused Review

The procedure used by DMH during this comprehensive review included four main components, listed below. Steps 1 and 2 were completed as part of an initial information gathering and preliminary analysis stage, while steps 3 and 4 were completed as the elements of the on-site system review. The four components of the qualitative focused review include:

1) Quantitative data review
2) MHP Pre-Review Questionnaire
3) Qualitative Focused Review Protocol
4) External Stakeholder Focus Groups

With respect to the performance of the comprehensive review--collecting information from a variety of sources, arriving at the findings, interpreting and contextualizing the findings, and providing conclusions, recommendations and technical assistance to the counties--it is very important to note that no single person at DMH is solely responsible for production of this report. The entire qualitative focused review process, including the reporting component, is based on a team approach with input from a wide variety of sources. For reference and completeness, the completed review tools used in the comprehensive evaluation are provided as appendices to this report.

Review Team Comments:
The following persons, agencies, or groups participated during the focused review and contributed to the information documented in this report.

A) <u>MHP staff that participated during the on-site focused review:</u>

1. Terry Boykins, TBS Program Manager
2. Paul McIver, Program Chief
3. Marion Sutherland, Quality Assurance
4. Pansy Washington, MH Clinical Program
5. Bryan Mershon, Clinician for Children's
6. Tanicia Trotter, MH Clinical Program
7. Ana Verdin-Hernandez, Children Clinical System of Care
8. Kimber Salvaggio, TBS Unit
9. Gloria Lare-Vasquez, Program Review

B) <u>Stakeholders that participated in the external stakeholder focus groups:</u>

1. *Administrative Staff*

2. *TBS Coaches within Behavioral Health in Los Angeles*
3. *Clinical Staff*
4. *Child Welfare Social Workers*
5. *Probation and Social Service Departments*

C) *Stakeholders that participated in the individual case review interviews:*

1. *Clinicians/Case Managers*
2. *Clients*
3. *Parents*
4. *TBS Provider (Coaches from County Mental Health)*

III. Comprehensive System Findings

This section of the report is intended to reflect the review team's observations and analysis from the broader perspective (e.g. systems and service/agency integration/coordination). This perspective considers all of the review tools collectively and all the elements involved in the provision of services to eligible class members taken in concert. The emphasis here is on interrelatedness, interdependence, cooperation and communication between individuals, agencies, systems, and processes.

Review Team Comments:
The LADMH has had many challenges in the last several years with providing EPSDT and specifically TBS to class members.

This report will address the challenges and recommend actions to be taken by the LADMH Issues to be addressed at the county level and between agencies include: minimal communication within the department and with other county departments, minimal commitment in providing EPSDT and TBS services to class members, and limited tracking of mental health case outcomes to improve the mental health system in Los Angeles County.

The review team highlighted the following items during the on-site focused review with LADMH staff and participating stakeholders:

Strengths:
1) LADMH contracts with 23 TBS providers. The county provides approximately 200 units of TBS. In addition, the team did not find any area within the county that TBS is not available.
2) LADMH has improved the authorizations by providing a web-based system that is a more effective procedure in providing status of TBS.
3) TBS is a valued service within Los Angeles county: All interviews reflected that TBS is a positive service and provides the extra support that class members need for a successful placement.

4) Los Angeles County has started co-locating Child Welfare, Foster Care, Mental Health and other social services in one location. This practice has improved communication and collaboration between Los Angeles county agencies in providing services to the class members.

Opportunities for Improved TBS in Los Angeles

1) Case reviews conducted as part of this review process led reviewers to conclude, LADMH is providing TBS in most cases to children at the highest level of care (RCL 14). The review team would encourage LADMH to review current practices and if this is the case, LADMH should review their comprehensive assessment process to be sure that assessments include consideration of TBS when medically necessary for class members at both lower levels of care such as RCL 12 and/or family homes and those being discharge from an inpatient setting or stepped down to a lower level of care.

2) During the individual case interviews, the review team found that LADMH could improve documentation to reflect more detail to allow for improved tracking. Documentation training and improved charting would improve LADMH's ability to track and improve service delivery to class members and other persons receiving mental health services.

3) Los Angeles County has started co-locating several agencies together including LADMH services. The structure for efficient inter-agency collaboration with high needs children is already in place; and the co-locating of agencies is expected to improve the delivery of mental health services including TBS.

4) Given the density of the population in Los Angeles County, LADMH will probably need to consider increasing capacity. In addition, LADMH should address and eliminate the misperception that there are " informal waiting list" for children receiving TBS. Although some individuals interviewed stated there was an informal short "waiting list" for class members no actual list could be found to exist by DMH reviewers. The perception that there are "waiting lists" is clearly a misunderstanding and should be addressed to ensure MHP staff and TBS providers have a clear understanding of how to access TBS.

5) LADMH contracts out all TBS and by report has provided a minimal amount of oversight and standards for quality improvement and performance accountability to TBS contractors. LADMH has provided a strong emphasis on understanding TBS criteria and documentation of medical necessity training to contractors. The DMH team would encourage LADMH to review current oversight and monitoring practices and as necessary increase oversight and trainings that included

strategies to improve quality improvement and performance accountability for TBS contractors.

6) Additional trainings would be helpful to improve outreach, documentation, assessments and skill sets for TBS contractors. LADMH participated in the initial training provided by State DMH through the California Institute for Mental Health (CIMH) regarding TBS and should continue to participate in additional training as it is offered.

IV. Specific Findings of the Case Reviews

This section addresses the findings of the review team from the case reviews that were conducted during the on-site review.

Review Team Comments:
The review team identified a sample of 21 cases to be reviewed during the focused review: 10 cases in which TBS had been or is being provided, and 10 cases of which were eligible class members, but did not received TBS. Of the cases reviewed 15 cases are currently residing in an RCL 12 or above.

Each case was assigned a person to review. Each case review analysis draws conclusions from the information gathered during the chart review and stakeholder interviews, and is presented as conclusions on each of the following dimensions:

a) Adequacy of access to services, including TBS.
b) Adequacy of capacity to provide service.
c) Accountability.
d) Evidence that TBS or other services are working.
e) Quality of TBS, when applicable.
f) Appropriateness of services to kids placed out of county, if applicable.

A summary of each case is included as Appendix 1 to this report.

V. Specific/Distinct Findings

Turning from the global to the specific, the following section will discuss individual findings that surfaced during the various stages of the comprehensive qualitative review process, and that were considered significant enough by the DMH review team to warrant specific mention.

Review Team Comments:
The review team found that there were three areas identified that generated concern, and warrant additional development and follow-up. LADMH will need to address: training to increase understanding of the various uses of TBS, increase the network capacity to provide TBS, improve systems to track and monitor of TBS cases and increase knowledge and skills to provide TBS to class members who are younger class members, however would benefit from TBS.

1. ***Training to stakeholders regarding TBS:***
As stated above, LADMH participated in the initial training provided by DMH through CIMH. LADMH should access and make additional training available to all MHP staff and contract TBS providers on the utility and benefit of TBS to class members. Training should be included for TBS coaches on behavioral assessment and documentation training to address the finding above regarding LADMH increasing documentation skills to improve tracking of all mental health services

2. ***Develop additional TBS capacity***
As described above, LADMH has 23 TBS contracted providers with approximately 200-250 TBS service units available to class members. Given the population density of the County, LADMH should consider ways to increase capacity as need increases.

3. ***Tracking and monitoring of TBS utilization in addition to other mental health and other social services that class members are receiving***
LADMH does collect aggregate utilization data of TBS; however; more detailed information is not tracked routinely. LADMH should consider adopting a more system that can provide managers and staff with more detailed reports to determine resource allocation in the mental health system. This would provide the necessary data to revise program disparities and could improve mental health service outcomes.

VI. Conclusions

The DMH Review Team, in light of a thorough and objective analysis of the findings mentioned above, has developed the following conclusions related to the infrastructure, process, and access and outcome issues connected to the evaluation of services to eligible class members in Los Angeles County.

VII. Recommendations

After carefully analyzing and evaluating the variety of information gained through the Focused Review process, the DMH review team has arrived at consensus regarding the primary recommendations we would like to present for the Los Angeles County MHP's consideration. The intent of these recommendations is that they not be viewed as prescriptive or definitively exhaustive of all options, but as an informative source of consultation that will provide high value to the county's own quality improvement and strategic improvement efforts. Ideally, we hope that your county's decision-makers and external stakeholders will find our recommendations to flow logically and reasonably from the results achieved through the comprehensive review.

The review team's recommendations are described below on two levels with consideration given to the likely time horizon (i.e. what can be done immediately or in the short run, and what may need to be approached from a longer-run strategic perspective), and also with awareness of the resource/scope intensity issues connected to a recommendation.

Review Team Comments:
Tactical/Operational Recommendations

1) **Establish a TBS Training Program:**
   DMH recommends LADMH establish a TBS training program for agencies, professionals and possible class members and family members. This training should include, but should not be limited to: class membership, appropriate uses for TBS, proper referrals, techniques on providing TBS and proper documentation and tracking of TBS.

2) **Increased TBS Capacity:**
   DMH recommends LADMH expand the available capacity of TBS for class members. LADMH is providing a fair amount of TBS; however, LADMH will need to increase TBS capacity to provide services to eligible class members who demonstrate medical necessity for TBS.

3) **Enhance Tracking System for TBS:**
   DMH recommends LADMH incorporate information about TBS utilization and other appropriate services by eligible class members into their quality improvement activities, including monitoring access, denials, modifications, and reductions in TBS.

Strategic Improvement Recommendations

The DMH review team recommends that the county implement a strategic improvement plan that addresses each of the recommendations above. DMH sees these recommendations as short-term, intermediate, and long-term goals.

In the short-term, recommendations 1 & 2 are essential for DMH and LADMH to improve access to and availability of appropriate services to eligible class members.

In the intermediate, recommendation 3 reflects DMH's desire for LADMH to develop a mechanism to track and monitor services to these beneficiaries and to incorporate findings into their quality improvement and utilization review processes, but recognizes that this recommendation is dependent upon reconciliation of the first 2 recommendations. Thus the review team anticipates that recommendation 3 would be implemented as part of LADMH' second stage of its strategic improvement plan.

In the long-term, recommendation 4 acknowledges a need to establish a LADMH training program and to improve county awareness of the availability of TBS.

VII. Appendices/Attachments

Review Team Comments: Ensure inclusion of all supporting documents, protocols, and forms with the formal report to the county. Included are tools used during the on-site review and completed by the DMH review team:

Appendix 1 – Individual Case Review Analyses
Appendix 2 – External Stakeholder Focus Group Analysis

Attachment A – Data Reports
Attachment B – Preliminary Analysis
Attachment C – Qualitative Focused Review Protocol (with MHP responses)

Appendix 1 – Individual Case Review Analyses

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #1

Case Review by: John McNay, LCSW

Facts: The information on this client was gathered from the review of the client's chart(s) and interviews with the client, his TBS provider and his therapist. There was an attempt by the reviewer to interview the client's father by telephone, but it was unsuccessful. The client is a 15 year-old Caucasian male residing in an RCL14 group home located in Los Angeles County where he was placed by Juvenile Justice. The client has been in this placement since 3/21/05 (4 months).

Client began receiving TBS on 3/21/05 (date of placement) and he was continuing to receive these services at the time of this review. The chart indicated that the most recent DSM diagnoses for the client were: Bipolar I Disorder, mixed, moderate; Disruptive Behavior Disorder NOS; Antisocial Behavior; Multiple Substance Abuse and Borderline Personality Traits; Psychosocial Stressors: Current involvement with Juvenile Justice System; Primary support group; Educational. GAF 35; Current psychotropic medications are Lithium and Serequel.

Summary: Client is from a broken home. His father and stepmother are his custodial parents. Client had two psychiatric hospitalizations for "Danger to Self" and "Danger to Others" (12/09/03 and 8/09/04). Client had two separate petitions against him in Juvenile Court for petty theft. He is currently a Ward of the Court and was placed by Juvenile Justice at his current RCL14 Placement after he failed a lower level placement due to aggressive behaviors. Behaviors documented by his current placement have included poor anger management as evidenced by his being aggressive and assaultive with peers and staff, hitting and throwing things, being verbally abusive to peers and staff, threatening harm and using disrespectful language. Poor impulse control (tries to grab female peers). Self injurious behaviors (cuts and scratches arms and attempts to AWOL when upset).

Over the past few weeks, there has been a marked improvement in the Client's overall behavior. He seems to have made a decision to work the program in order to reach his goal of going home. According to his therapist and TBS provider the client is currently doing very well. They identified the following as contributing to the change in his behavior: (1). Client responds well to TBS. For example, TBS provider started following him to his room when he would take a "time out", give him time to calm down, and then help him to process. He now returns to class on his own. (2). His Probation Officer read him the riot act. (3). He is motivated by his "level" in the placement and has learned not to "lose it" when he loses his composure. (4). Use of Short Term Contracts. (5). Lab tests

showed that the medication levels were too low and the medications were adjusted. (6). Client clearly made a decision to change.

Conclusions:

a) Adequacy of access to services, including TBS. There were psychiatric hospitalizations on 12/9/03 and 8/9/04 and an RCL12 placement prior to TBS being requested and authorized when client was admitted to the RCL 14. TBS services have been successful in the client's ability to maintain this placement.

b) Adequacy of capacity to provide service. Client's placements were under the authority and coordinated by the Public Defender and the Probation Department. The RCL 12 placement was not adequate for this Client. The RCL14 placement, together with TBS, appears to be meeting the needs of the client.

c) Accountability. There are monthly Team Meetings at the Group Home, which are attended by both the therapist and the TBS provider. Also, the therapist and the TBS provider talk to each other as needed. Parents are actively involved in Family Therapy.

d) Evidence that TBS or other services are working. The client reported liking his placement and reported that he is "learning ways to do things". He reported that TBS helps him deal with his anger. When the client was asked about the overall service performance, the Client responded "l00%". Both the therapist and the TBS provider reported a marked improvement in his behaviors. Although the decision is up to the Probation Officer, The therapist believes that the plan is for the client to return home from this placement.

e) Quality of TBS, if TBS was provided. When the client was asked about the overall service performance, he responded "100%". The review of the chart and the telephone interviews suggest a well-coordinated program that is producing positive measurable results.

f) Appropriateness of services to kids placed out of county, if applicable). N/A

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #2

Case Review Team: Rose Lira

Facts: This is a soon to be 16 year old (DOB 8/11/1989) Hispanic female, born in Mexico brought here at the age of 7 abandoned by her mother and mother's boyfriend. The child was left along with two siblings with maternal grandmother who was having difficulty coping with this child's out of control behaviors. The grandmother requested help from LADMH on 2/25/01 when the child ended up in long term foster care. She was placed in SED classes Special Ed with average grades. By the age of 11 she had been in 11foster home and 2 group homes before being placed in a RCL 14 where she was approved for TBS and Intensive Day Treatment.

Her diagnoses were Axis I Depressive Disorder NOS Axis II & Axis III-none Axis IV-primary support group; social environment; other psychiatric problems. She was prescribed Trazadone 200 mg/ twice a day on 9/16/2004. When she was placed with Aviva RCL12 they requested TBS beginning 4/28/04-5/28/04 then there is a break with the second request being 7/29/04-8/29/04 then a request for TBS 9/8/2004 authorized 9/16-11/14/2004 for 60 days/ 120 hours the targeted behaviors was to decrease angry outburst, decrease excessive verbal abuse and aggression with peers and staff from 3 times a week to 1 time weekly. The progress notes of 11/14/2004 stated she was making progress as had been expected no re-authorization was requested. She AWOL'd from the facility and broke her probation-Robbery, drug possession and assault with a deadly weapon she was incarcerated and awaiting mandatory placement in a locked out of county facility. She was not currently receiving any mental health services through the juvenile justice system.

Summary: Probation officer reports that the services in the hall were limited to those who had serious mental health problems and she was being transferred soon to a mandatory placement where she could receive mental health services. DCF worker reported little information their focus was only towards placement.

Conclusions:

a) Adequacy of access to services, including TBS. The progress notes of 11/14/2004 stated she was making progress as had been expected no re-authorization was requested.

b) Adequacy of capacity to provide service. This child received services when requested.

c) Accountability the MHP. The MHP relies on the information from progress notes and also requests the information they need prior to re-authorizing TBS and other authorized services.

d) Evidence that TBS or other services are working. This child was making progress in mental health treatment until she entered the juvenile justice system.

e) Quality of TBS. TBS appeared effective when it was provided.

f) N/A

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #3

Case Review Team: Eddie Gabriel

Facts: The information on this child was gathered from the review of the child's chart, and interviews with the mother, therapist, client and TBS Coach. The client is 18 year-old African/American male. He is currently receiving TBS, was placed in a Community Treatment Facility (CTF), and is currently at a Board and Care facility.

The client was assessed and authorized for TBS during an inpatient hospitalization episode in April 2005. The client is diagnosed with psychotic disorder, no other symptoms. His medications include Wellbutrin, QAM & QPM, Abilify, Depakote, and Benadryl. His global assessment o functioning is 40. The client exhibits poor self-control (agitates and provokes peers), poor boundaries with peers, poor hygiene, and is often paranoid in thinking. The client also has a history of substance abuse.

Summary: The client is transitioning out of the children system. All persons involve in the case appear to be on the same page and are in agreement with the client's next placement. The plan is for the client to be placed in transitional living, and ultimately be reunited with his mother.

Conclusions:

a) Adequacy of access to services, including TBS. The TBS services were extremely helpful. Although slow at the start, the client made dramatic improvement from the beginning according to the TBS coach. TBS will terminate on August 10.

b) Adequacy of capacity to provide service. It appears that the client received the appropriate services after his hospitalization. There is no identified need to continue TBS to assist in the placement to transitional living.

c) Accountability. All parties have been actively involved in the client's case. There were no complaints with actual services provided, however, the mother indicated disappointment with the Board and Care due to their slowness in obtaining the client's Social Security Insurance benefits.

d) Evidence that TBS or other services are working. Based on the fact that the client will be placed in transitional living and ultimately be reunited with his mother, services received appear to be successful.

e) Quality of TBS, if TBS was provided. The client has improved his affect (smiling and staring), and hygiene. He goes and stays in school and his group therapy session. TBS gave him motivation to turnaround.

f) Appropriateness of services to kids placed out of county, if applicable). The client is not placed out of county.

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #4

Case Reviewer: Kathryn Riggs, LCSW

Facts:
The information for this child was gathered from the review of the child's chart, interviews with the client's former legal guardian, maternal Aunt and DCFS worker. At the time of this review, the client was unavailable due to her admission to an acute care medical hospital for evaluation to evaluate her medications regime, thyroid evaluation, and take out a metal plate in her ankle, per court order. Client is a 15-year-old, Caucasian female, presently living in a level 14. She has received TBS services in the past; however, is not receiving TBS services currently; she is no longer at risk for hospitalization.

The client has been in the system since age 4, when she was found on the streets half-naked, and placed in a group home due to neglect. Chart and stakeholders reveal a history of domestic violence and drug abuse in the home. At age 6 her maternal Aunt became her legal guardian, whom she lived with until age 14, when the client became unmanageable, as evidenced by hospitalization three times, and she is reported to have kicked a cop. The chart reveals the following diagnosis:

Diagnosis:	**3/16/05**	**10/15/04**
Axis I:	Bipolar Disorder Mixed	Major Depression w/Psychotic features
Axis II:	None	Oppositional Disorder
Axis III:	Asthma	
Axis IV:	Problem w/ Primary support	
Axis V:	35	

Medications: Seroquel for Psychotic features, Depakote for Mood

Summary:
The client's social worker and Aunt were both informed of this case. TBS was authorized for a short period when she was at-risk of losing her placement.

Conclusions:

a) *Adequacy of access to services, including TBS*. Aunt was unaware of services available for her family prior to giving up guardianship, including that TBS services can be provided in the home. Presently she "is done" and is uninterested in pursing this option, she has dropped her legal guardian status due to fear of "legal liability" of clients' out-of-control behaviors. She was aware of TBS services that client has received in the past, "she liked it", while client was in placement, "only for 6 weeks".

b) *Adequacy of capacity to provide services.* It appears that the client has received TBS services in the past, at a level 14 for 6 weeks, and then the services were discontinued. Presently there is no plan to provide TBS.

c) *Accountability.* Client doing well in school receiving grades of B's and C's her Aunt reported. Aunt reported that client did well in Special Ed School, for the first 7 years she lived with her, and then placed in residential treatment, which worked well for her. She graduated 8th grade, then started to have physical fights with boyfriend, and ended up hospitalized 4 months later, due to assaultive behaviors and no self-control. Biological mother lives in Los Angeles County, she is reported to have been attending Domestic Violence classes, and has a history of substance abuse, unclear of level of involvement of mother.

d) Evidence that TBS or other services are working. Client received TBS, extensive therapy, and medication throughout program.

e) Quality of TBS, if TBS was provided. Chart reveals that client did reduce her aggressive behaviors during TBS services.

f) *Appropriateness of services to kids placed out of county, if applicable.)* The client was placed with her aunt in Orange County and she was from Los Angeles County.

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #5

Case Review Team: Rose Lira

Facts: This is a soon to be 17-year old black female (DOB 8/22/88). She and her younger siblings were removed from her biological mother's custody when this child, the eldest was seven (7) she was already described as being "parentafied". Her diagnoses are listed as Axis I Bipolar disorder, depressed type with psychotic features, Post traumatic stress disorder; No Axis II Axis III list obesity with other hyper alimentation and psuedo-seizures Axis IV problems with primary support group and social environment. She was prescribed Zyprexa 15 mg every morning & at bedtime; Topamax 100 mg twice daily; Triliptal 60 mg twice a day; Prozac, Prolixin and Synthroid (dose unknown). She has been in & out of placement returning to her mother so that she could help take care of her siblings. She was considered for TBS until she was placed in an RCL 12 in addition to Intensive Day Treatment-full day. The first authorization for both was upon admission to Penny Lane on 8/6/2003-10/6/2003 for 120 hours/60 days the first re-authorization was 10/7/2003-12/6/2003 again for 120 hours/60 days the progress note stated the progress was not as expected. Elimination of property destruction was replaced with more dangerous behaviors (tying a shirt around her own neck) and threats towards others were replaced by charging at the staff with a pair of scissors. She apparently was transferred to Starview treatment facility (locked) where she currently resides. TBS was requested again and approved for 9/24/2004-11/22/2004 with a re-authorization dated 11/23/2004-1/21/2004 they were authorized for 120 hrs/ 60 days. Both of these residential facilities provide all the treatment modalities including a non-public school.

Summary: The therapist interviewed felt that the client continued to do well after the TBS was discontinued but they would not hesitate to request TBS services at another time if needed. The client described TBS as "talking with an adult" she felt it was helpful. She has hopes to leave when she turns 18 so she is taking some classes on independent living. The TBS coach who have worked with her in the past report she has made progress towards this goal. Family does not visit often they promise but do not follow through. When they leave after a visit staff report that the client reacts with some outburst of maladaptive behaviors.

Conclusions: (Here are the key points that each analysis should ultimately answer:

g) Adequacy of access to services, including TBS –TBS and Intensive Day Treatment were provided to the client.

h) Adequacy of capacity to provide service. The MHP does a large number of authorizations and re-authorizations. This client was provided TBS upon request.

i) Accountability the MHP does require progress report to be submitted with the re-authorizations and follow up if the information is not clear or adequate for them to make a decision.

j) Evidence that TBS or other services are working is established through the use of progress notes and reports.

k) Quality of TBS. The TBS provided appears to be appropriate.

l) Appropriateness of services to kids placed out of county, if applicable) N/A

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #6

Case Reviewer: Kathryn Riggs, LCSW

Facts:
The information for this child was gathered from the review of the child's chart, interviews with the client, TBS provider, client, and group home administrator. Client is a 17 year old, African American female. She has received TBS services in the past, and presently lives in a level 11-group home and is not receiving TBS services. The group home is loosely structured with the intent in assisting in the client's emancipation. There was disagreement amongst the stakeholders as to the reality of this goal.

The client has been hospitalized 11 times beginning in October 2003, she was removed from her home and placed in a group home in January 2004. Her first hospitalization, age 16, due to suicide attempt. During this stay she disclosed that her siblings have sexually abused her since she was 6. She was removed from the home and placed in foster care when Mom failed to respond to the psychiatric hospital case manager during discharge planning process. She was placed in foster care, residential treatment and other group homes. She was a difficult placement due to her self-destructive history; she tried to hang herself at a residential treatment facility. Her most recent hospitalization was December 2004. She has a history of self- abusive behaviors, depression, suicide attempts, AWOL from group home, sexually inappropriate behaviors and poor impulse control. The chart reveals a diagnosis of Major Depression, PTSD, and she was reported to be developmentally around age 5. Her medication regime has included Prozac and Seroquel.

Summary:
The individuals interviewed were not well informed of the current status of the client. The TBS provider thought that the client was still in a locked facility; in reality, she had been discharged back to the group home, level 11, 45 days ago. Presently she is in a group home that is geared towards emancipation and is taking a computer class at a junior college.

Conclusions:

g) *Adequacy of access to services, including TBS.* The client has received TBS services prior to last hospitalization; however the group home administrator has not contacted the TBS since she has returned.

h) *Adequacy of capacity to provide services.* Prior to most recent hospitalization the TBS provider arrived at the group home to find that the

client wasn't there. It was revealed that although the days/hours were adjusted to the group home schedule, repeatedly the client wasn't available at the time the scheduled appointment. Both the TBS provider and the group home administrator acknowledged that there was a conflict between the two of them. "It wasn't a good fit- between the TBS and group home" according to the administrator. This writer's impression is that there were unclear boundaries, confusion about the purpose and role of the services of TBS services. In addition, the benefit to the client and group home of having TBS involvement.

i) *Accountability.* The individuals interviewed indicated that the DCFS worker wasn't easily accessible and lives in a different town. This writer also was unable to communicate with her, despite multiple voicemail messages. The TBS contractor and Group Home operator did not give the impression that there was a "team" approach with the best interests of the client at the forefront.

j) *Evidence that TBS or other services are working.* Prior to her last hospitalization, client was receiving individual therapy and TBS at the group home. The chart revealed the client also participated in Day Treatment, history of case management, therapy from an intern from another provider at the same time. In November she was having flashbacks, losing consciousness, she was hospitalized when she fainted in the shower. TBS services were increased to address coping skills. Despite these attempts the client was hospitalized.

k) *Quality of TBS, if TBS was provided.* Client has received TBS services, which the client felt was a benefit. However, due to the lack of cooperativeness and coordination between the provider and the group home administrator the client may have benefited as much as she may have.

l) *Appropriateness of services to kids placed out of county, if applicable.)* NA

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #7

Case Reviewer: Kathryn Riggs, LCSW

Facts:

The information for this child was gathered from the review of the child's chart, interviews with the client, fraternal grandmother, father, therapist, and LA Social Services DCFS worker. The client is a 10 year old, AA, male. He has not received TBS services in the past, and currently lives with his grandmother.

The client has never been in placement; however, he was at-risk for placement when there was a Domestic Violence episode, September 2004, while he was attending school. Client was at-risk to be removed from his parent's home; however, his grandmother picked him up from school and he has lived there since.

All stakeholders validated that this client has not been in placement at any time, nor met criteria to be a part of the focus review.

The client's diagnosis was Adjustment Disorder w/ mixed anxiety and depressed mood; he has no history of medications. The client did have some "disruptive behaviors" at school, such as talking during class, cursing and poor attitude intermittently, which was addressed by the teacher with re-direction. (These behaviors have been directly related to broken promises from his mother.)

Summary:

The stakeholders were informed of the current status of the client. The fraternal grandmother and father are very involved with meeting the needs of the client who has been adjusting well to living with grandmother. The client is looking forward to moving back home with his father. Parents are estranged; the client's mother is inconsistent with her involvement. There is a pending court date next month where it will be determined if the client will return to his father's home, or continue living with his grandmother.

Conclusions:

m) *Adequacy of access to services, including TBS.* Clients therapist and DCFS worker are aware of TBS services and felt that they would be too intensive for this client. Client's therapist assessed for TBS services on intake and determined that there was no need.

n) *Adequacy of capacity to provide services.* The site where the client receives individual and group therapy in on his school grounds, where TBS is also available. In addition the family receives family therapy in the home.

o) *Accountability.* As previously stated the client's father and grandmother are actively involved. The client will continue to receive counseling during the transition home. There has been no need for an IEP client receives B's and C's on his report card.

p) *Evidence that TBS or other services are working.* The client is scheduled to return to his father's home next month, pending a court's decision. The court had father attend parenting classes and domestic violence classes, which he has successfully completed.

q) *Quality of TBS, if TBS was provided.* None needed, nor provided.

r) *Appropriateness of services to kids placed out of county, if applicable.)* NA

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #8

Case Review Team: Troy Konarski, Anne Murray, Rose Lira, Eddie Gabriel, Kathryn Riggs, John McNay

Facts: The information on this child was gathered from the review of the client's chart(s) and interviews with the client's mother and therapist. There were multiple attempts to interview the client's Attorney but he was in Court and did not call back. Mother requested that we not interview the client because of concerns that it might increase her level of stress. Client is a 6 year-old Caucasian female residing at home with her mother and sister. Client lived with her maternal Uncle for a few days when Mother was jailed for spousal abuse but has never been placed out of the home by DCFS. Client witnessed spousal abuse in both directions.

Client was never eligible for TBS because her placement at home was never in jeopardy. The most recent diagnoses in her chart were Separation Anxiety Disorder (Primary); Post Traumatic Stress Disorder (Secondary). Psychosocial Stressors: Primary Support Group; GAF 35. Medications: None.

Summary: After she was separated from her Mother for several days when her Mother was in jail, and subsequent to witnessing spousal abuse (by both parents), client became very agitated and cried when she was separated from her Mother and also had trouble sleeping. Weekly Individual therapy is being provided to client, her sister and their Mother. They also receive Family Group Therapy weekly. The outpatient case was opened on 10/13/04.

Therapist reported that the client's separation anxiety is improving and that she is making significant behavioral progress. Client is currently having issues about visits with her Father, which the therapist described as disruptive. Therapist reported that client's life is now more structured. Mother reported seeing behavioral improvement in the client, her sister and herself. She reported improvement in her disciplinary skills.

Conclusions:

a) Adequacy of access to services, including TBS. Client did not qualify for TBS. No problems noted with access to the outpatient services received.

b) Adequacy of capacity to provide service. Client's Mother reported that the services provided were "great".

c) Accountability. The client's chart was in good order and met reporting requirements. It was evident that there was close coordination between the therapist, the school and client's Mother.

d) Evidence that TBS or other services are working. Behavioral improvement was reported by both the client's therapist and Mother. When asked how she would rate the services received, the client's Mother reported that on a scale of 1-10, a 10.

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #9

Case Review Team: Eddie Gabriel

Facts: The information on this client was gathered from the review of the child's chart, and interviews with the client, non-biological aunt, group home operator, and therapist. The client is a 16-year-old African-American male. He has not received TBS. He is currently placed in an unknown level group home, but is the responsibility of the Juvenile Justice System.

The client is diagnosed with other depressive disorders and ruled out bipolar disorder. He has a history of frequent incidents of threatening, provoking, or assaulting peers/staff. He is currently taking no medications. The client was previously placed at the Dorothy Kirby Center, but due to 3 fights was out in six weeks. Court ordered current placement (client remembered the telephone number of current placement since he was a previous resident in 2002 for 4-5 months). If current placement fails, the client will be placed in the California Youth Authority (CYA).

Summary: The non-biological aunt and group home provider are well of the client's circumstances. The client's biological parents are not involved with his case. If the client does not successfully complete his current placement he will be placed in the CYA.

Conclusions:

a) Adequacy of access to services, including TBS. The client was previously in Juvenile Hall, then Dorothy Kirby Center, and now his current placement. He receives all services from the group home. He is authorized to receive Day Treatment Intensive services five times per week through August 21.

b) Adequacy of capacity to provide service. Since the client is under the jurisdiction of the Probation Office, it is unknown.

c) Accountability. The biological parents are not involved. The non-biological aunt is willing to bring the client home when appropriate.

d) Evidence that TBS or other services are working. The group home operator has indicated that the client has not been a problem since being placed. Although the client should be at the eleventh grade level he only at fourth, due to low self-esteem. The client likes his current placement. He is learning how to control his anger and know himself better. He has the ability to deal out in the community, which will prepare him for reunification with his non-biological aunt.

The non-biological aunt also has expressed satisfaction with the services provided at the current placement.

e) Quality of TBS, if TBS was provided. The client has not received TBS.

f) Appropriateness of services to kids placed out of county, if applicable). The client is not placed out of county.

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #10

Case Review Team: Anne Murray, LCSW

Facts: The information on this child was gathered from the review of the child's chart(s) and interviews with the client's social worker/legal guardian and his therapist. The client is a 12-year-old male of Caucasian and Hispanic descent residing in an RCL 14 group home. He had been placed in four different foster homes and two group homes prior to this current placement. He has received TBS. There have been three approvals for TBS, the last one in June 2004.

The child's biological mother died when he was age 2 and their father who was extremely physically and emotionally abusive then cared for the boy and his sister. He would not allow the children to see their grandparents after the mother died even though the relationship was very important to the children. The children were removed from the care of their father when the client was age 9 and the father was incarcerated. The neighbors of the family were apparently very worried about the children but they did not want to contact the authorities due to fear of the children's father. The chart included a number of DSM diagnoses for the client: major depressive disorder, posttraumatic stress disorder and encopresis.

Summary: The child has made progress in the group home placement. He continues to struggle with aggressive behavior when he thinks he is not being heard. He has verbal outbursts, poor frustration tolerance, feelings of hopelessness and suicidal ideation. He has been very assaultive at times.

Conclusions:

a) *Adequacy of access to services, including TBS.* This is a very troubled child and he is now receiving services that appear to be very helpful to him. There has been some improvement in functioning since his placement in the RCL 14 group home.

b) *Adequacy of capacity to provide service.* The county MHP has a good capacity to provide services to children. The children referred for TBS appear to receive approval in a timely manner. There do not appear to be barriers to children receiving TBS in Los Angeles County particularly when the child is placed in high-level residential treatment.

c) *Accountability.* There was coordination in the case as evidenced by the review team notes in the file. There has been service and placement coordination for

the client and his family. The group home documentation from his current placement was quite descriptive and included the child's progress toward treatment goals. The reports included interventions, outcome indicators, strengths, and needs, visits made to the child, school progress and the discharge plan. The therapist at the group home and the child welfare worker both reported having an excellent working relationship and they felt this had greatly benefited the child.

d) *Evidence that TBS or other services are working.* The data that was available to the review team indicated that this child had never received TBS. The child welfare worker though believes the child did have TBS at one time. The MHP later located some TBS documentation, which was brought over to the review team from the contracted provider.

e) *Quality of TBS, if TBS was provided.* Documentation from the authorization unit indicated that the TBS seemed to be more of a "big brother' type of service in which there was not a clinical focus on behavior modification. The Department of Children and Family (DCF) worker believed the TBS was not of a high quality when the child first received the service. A progress note from another authorization period indicated the child showed little progress and was resistant to using TBS. The plan for this child is reported to be a future foster home placement close to the home of the child's grandparents when he is ready for this lower level of care.

f) *Appropriateness of services to kids placed out of county (if applicable).* The child is not placed outside of the County. The services are coordinated through the DCF social worker.

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #11

Case Review Team: Ann Murray, LCSW, DMH Policy

Facts: The information on this child was gathered from the review of the child's chart(s) and interviews with The client is a 10-year-old African American female. She is not currently receiving TBS but did receive these services in the past.

She recently moved from an RCL 12 group home into foster care in Rialto, CA. located a short distance from the Los Angeles County offices. Her two siblings are placed in the same home and also a fourth unrelated child. It was difficult to gain a complete picture of this case because the number of reviews and the information in the client's chart was limited.

The client was placed in the foster care system at a young age. The child is currently an open Department of Children's Services (DCS) case. The chart included a number of diagnoses for the client: intermittent explosive disorder, posttraumatic stress disorder and oppositional defiant disorder.

Summary: The reviewers were able to meet briefly with the foster mother and the child. The client did not respond to specific questions about TBS and the foster mother had limited knowledge about these services.

Conclusions:

a) *Adequacy of access to services, including TBS.* The client was identified as a child who needed TBS and case management services. The evaluation occurred and the necessary referral was completed.

b) *Adequacy of capacity to provide service.* TBS provided appeared adequate.

c) *Accountability.* The MHP reviews progress notes to assure services are provided in an accountable manner.

d) *Evidence that TBS or other services are working.* Although information in this case was limited, there was no sign services being provided now or in the past were insufficient in any way.

e) *Quality of TBS, if TBS was provided.* Quality appeared adequate.

f) *Appropriateness of services to kids placed out of county (if applicable).* The child is not placed out of Los Angeles County.

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #12

Case Review Team: Troy Konarski, Anne Murray, Rose Lira, Eddie Gabriel, Kathryn Riggs, John McNay

Facts: The information on this client was gathered from the review of the client's chart(s) and interviews with his Mother, therapist and the DMH AB2726 liaison. The client is an 18 year-old male who turned 18 on 7/25/05 and was transferred to a Transitional Youth Facility on 7/24/05 by Adult Services. Therefore, this Focused Review Team had not scheduled him for an interview.

Client was placed out of State in Colorado for 18 months under AB2726 but was then returned to California in order to better meet the AB2726 requirement for family involvement with the goal of family reunification. He was placed at an RCL 14, on 11/04/04 and discharged to the Transitional Youth Facility on 7/24/05 (8 months). The most recent DSM Diagnoses in his chart were Dysthymic Disorder; Impulse Control Disorder, NOS; Parent-Child Relational Problems; Borderline Personality Disorder; Histrionic Personality Disorder; Narcisistic Personality Disorder; Asthma, unspecified; Problems with Primary Support Group. GAF: 40. His psychotropic medications at the time of discharge from the RCL14 Locked Facility were Lexapro and Trazadone. The documented reasons for the medications were depressed mood, suicidality, impulsivity, mood swings and insomnia.

Summary: The LADMH AB2726 Liaison on this case reported that the Client was not a danger to self or others, nor was he an AWOL risk at the time of his transfer from the Colorado Placement to the RCL14, a locked facility. When asked why the Client was placed at an RCL 14, locked placement, the AB2726 Liaison reported that the RCL 12's would not take him. When asked if TBS was considered, she indicated that they do not use TBS with AB2726 placements.

Conclusions:

a) Adequacy of access to services, including TBS. TBS was not considered for this client even though he met the class requirements. A member of the TBS Focused Review Team discussed his concerns about TBS not being offered in this case with Deputy Head of the Department Terri Boykins on Thursday. Friday morning before the Exit Meeting, Deputy Head Boykins, reported that she had already had a meeting with those concerned to clear up the misunderstanding that TBS can not be authorized for clients placed under AB2726 when they have full Medical.

b) Adequacy of capacity to provide service. With the change in understanding indicated in sub-paragraph a) above the capacity to provide TBS to clients with AB2726 placements and full Medical should be much improved.

c) Accountability. There was evidence of close coordination between the DMH AB 2726 Liaison, the Therapist and the client's Mother. The client's Mother reported during the telephone interview that the AB2726 liaison was always helpful and indicated that she would not have known what to do without her help.

d) Evidence that TBS or other services are working. Client's therapist reported that the symptoms of Depression had improved but that there were still problems related to his diagnosed Personality Disorders. Client's Mother reported "It worked for him" and that he made progress. She was especially pleased with his educational progress.

e) Quality of TBS, if TBS was provided. N/A

f) Appropriateness of services to kids placed out of county, if applicable). N/A

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #13

Case Review Team: Anne Murray, LCSW

Stakeholders Interviewed: client, two therapists, and client's mother

Facts: The client is a 17-year-old African American female who is currently in Los Padrinos Juvenile Hall. She is awaiting placement and is currently being interviewed by several group homes for potential placement. The child has been known in the mental health system for many years. She has had at least one inpatient psychiatric hospitalization and has received mental health services since age five. She has been placed in juvenile detention several times according to the child's file and the interviews with the clinicians at juvenile hall. The chart included a number of diagnoses for the youth that include attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder and bipolar disorder, not otherwise specified (NOS). The global assessment of functioning (GAF) was generally determined to be in the range between 35 and 40. The child has received services that include case management, medication, individual therapy, group therapy and TBS services provided while she was placed in a group home. The youth has taken Risperdal and Seroquel. She was evaluated and found seriously emotionally disturbed (SED) and she has a school individual education plan (IEP). The child is very behind academically as the result of her sporadic school attendance.

Summary: The client's mother has been very supportive of the child but the family became overwhelmed with the child's escalating acting out. The child has a long history of mental illness and difficulties in school. She eventually got into legal trouble and was placed on probation. She is receiving mental health services in juvenile hall and her legal status has resulted in juvenile probation being the lead in the case. She has a history of drug use and tends to place herself in dangerous situations when not in custody. The court has ordered a yearlong placement in residential treatment. She will be in a group home after she has turned 18 years old. The two clinicians that were interviewed both reported that the child has a lot of potential. She is reported to be likeable, bright and articulate. She tends to act out when she does not get her way but also tends to be quite helpful and compassionate with her peers when she is more stable.

Conclusions:

a) Adequacy of access to services, including TBS. The available data from the MHP indicated the child had never received TBS. However, the child's mother was certain her daughter received TBS when she was residing in a group home.

No TBS documentation was available to the review team. The child's mother indicated TBS was beneficial when the child was receiving the services but her unsafe behavior still resulted in a need for her eventual placement through the juvenile probation system.

b) *Adequacy of capacity to provide service.* Los Angeles County appears to have a good capacity to provide TBS.

c) *Accountability.* The client's mother has been very grateful for the services her daughter has received. She believes her daughter is mentally ill and she wants her to receive the services. She has been less pleased with the performance of Child Welfare Services. The DCF workers have changed a lot and it was reportedly very difficult to reach the workers. The client's mother and the clinicians reported that TBS was more needed during the multiple times that the client had been returned home. The clinicians at juvenile hall indicated they were aware of TBS but did not know the process for referring a child for TBS.

d) *Evidence that TBS or other services are working.* The child's behavior continued to escalate while she was in the home. The youth was intermittently in juvenile hall and then discharged back to the home. The client's mother reported that services were often requested when the client returned home. The client would be refusing to take her medication, running away from home, not attending school and hanging out on the street with her friends. The therapists at juvenile hall are employed by the MHP but are assigned to this site. Mental health services start very quickly in juvenile hall if the child has received them in the past and all children are approved for the services when it is needed even if the child has not has the services in the past. Every child receives a mental health evaluation when admitted to juvenile hall.

e) *Quality of TBS, if TBS was provided.* The client was listed in the case sample list as not having TBS. The child's mother reported that she is certain her daughter did have TBS. The chart that was available to the review team did not contain any TBS progress notes. The only notes contained in the client's file were for the mental health services provided in juvenile hall.

f) *Appropriateness of services to kids placed out of county (if applicable).* The child is not placed outside of the County.

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #14

Case Review Team: Troy Konarski, Anne Murray, Rose Lira, Eddie Gabriel, Kathryn Riggs, John McNay

Facts: The information on this client was gathered from the review of the client's chart(s) and interviews with his Foster/Adopt Mother (Paternal Aunt), his Therapist and his former DCFS Adoptions Worker, who is now a Supervisor and no longer on the case. His Foster/Adopt Mother stated that the client was too young to be interviewed. Client is six year-old Caucasian/Hispanic male who are currently living with his Foster/Adopt Family. After the Foster/Adopt placement with the family of his biological Father's twin brother, the biological Father reportedly became intrusive and demanding. This resulted in the Uncle and Aunt asking to have the client removed. They immediately realized that they had made a mistake and asked to have him returned. He was returned in about six months.

The outpatient case was opened on 5/18/04 and closed on 12/20/04. Therapist did not consider TBS because the child's placement was never in jeopardy because of his behavior. Presenting problems were difficulty sleeping, lying and aggression at school. The chart indicated that the DSM Diagnosis was Adjustment Disorder, Mixed; Psychosocial and Environmental Stressors: Problems with primary support group; other psychological and environmental stressors. GAF 35; No psychotropic medications were prescribed.

Summary: Client experienced a broken home and then also being removed from his Foster/Adopt Home for about six months. However, his Foster/Adopt Family is very committed to him and is extremely supportive. Foster/Adopt Mother actively participated with the client in play therapy for seven months. The play therapy was videotaped. Then the therapist worked with her to increase her knowledge of age appropriate behaviors and parenting strategies/communication skills, to decrease the client's aggressive behaviors.

Conclusions:

a) Adequacy of access to services, including TBS. The chart indicated that the initial contact was on 2/26/04 and that a phone screening was done on 3/24/04 but the outpatient chart was not opened until 5/18/04. TBS was not offered because the client did not meet the class requirements.

b) Adequacy of capacity to provide service. The Play Therapy provided was effective but as indicated under a) above, there was a span of 3 months between the initial contact and the case being opened. The reasons for the delay were not evident but could indicate a problem with capacity.

c) Accountability. The telephone interviews indicated that there was effective coordination between the Therapist, CSW and the FOS/Adopt Mother.

d) Evidence that TBS or other services are working. The Case Review Form indicated that aggressive behaviors had decreased from daily to weekly and that per Mother, sleep is better. Foster /Adopt Mother reported during the telephone interview with her that she would rate the overall service/practice performance as "Excellent".

e) Quality of TBS, if TBS was provided. N/A

f) Appropriateness of services to kids placed out of county, if applicable). N/A

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #15

Case Review Team: Rose Lira

Facts: This is a 15-year old Hispanic female. She carries the following diagnoses Axis I Adjustment disorder with depression and anxiety also Depressive disorder. Nothing was listed on Axis II- V. She was first open to out patient specialty mental health services 2/22/01 after an acute hospitalization where she reported having been sexually abused by her stepfather that had prior law enforcement involvement for spousal abuse. This child was removed from the home and place in Sycamores' RCL 12 where TBS was requested. The information containing the TBS portion was not available for review. The current whereabouts of this child is currently unknown. She eventually had to go to court to answer to her claims of being sexually abused where she recanted her claims and allowed to return home when she ran away and currently remains missing.

Summary: The therapist for the contract agency where this child received individual therapy reported the chaotic family life kept her treatment limited. The family often fell out of eligibility for Medi-Cal services due to mother's failure to return required forms. This made therapy somewhat ineffective.

Conclusions:

m) Adequacy of access to services, including TBS was hard to assess due to the limited amount of information available.

n) Adequacy of capacity to provide service again unable to assess.

o) Accountability for this child it was poor complicated by her falling in and out of eligibility to Medi-Cal and services.

p) Evidence that TBS or other services are working- unable to assess

q) Quality of TBS, if TBS was provided- unable to assess

r) Appropriateness of services to kids placed out of county, if applicable)-N/A

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #16

Case Review Team: Anne Murray, LCSW

Facts: The information on this child was gathered from the review of the child's chart(s) and interviews with the client's social worker/legal guardian and his adoptive mother. There was also an interview with a supervising MHP clinician who was familiar with the child and his mental health services.

The client is a 6-year-old male of African American/Mexican descent residing in the home of his adoptive mother. His biological parents abandoned the child. The involvement of the Department of Children and Family (DCF) began and he became a ward at age 2. He was adopted in December 2004 but he had already lived with his adoptive mother for two years as a foster home placement. The adoptive mother cares for the client and his two siblings. Another sibling is placed in a group home out of the area. The boy and his siblings were severely abused by the biological parents. The adoptive mother suspects the child was locked in a closet for long periods of time without access to food.

The chart included a number of DSM diagnoses for the client: attention deficit hyperactivity disorder (ADHD), mixed receptive expressive language disorder, borderline intellectual functioning and post traumatic stress disorder. The child's GAF was determined to be 33 according to the child's record. Abilify has been prescribed for the child for the treatment of his aggression. A thorough evaluation of the child completed by a psychologist described many challenges for this boy. He was not toilet trained until age 4 ½. He is able to walk up and down stairs but he cannot alternate his feet. He has poor coordination. He is only now beginning to jump and he is not able to pedal a tricycle. He shows no awareness of danger in his environment and he is extremely impulsive.

Summary: The child was referred by East Valley Regional Center. The child has made progress in the last few months but he continues to struggle with feelings of anger when others have trouble understanding what he is trying to say. He has verbal outbursts, poor frustration tolerance, and aggressiveness toward his siblings and a short attention span. His adoptive mother reported that the child fidgets a lot, screams when he is frustrated and has a lot of trouble expressing self due to deficits in expressive language. It is very difficult to understand anything he says. He tends to fall often and does not appear to be affected by pain even when he is injured. The interviews also indicated that the child could be very warm and sweet.

Conclusions:

a) *Adequacy of access to services, including TBS*. This is a very troubled child with emotional and developmental difficulties. It was not easy to determine if he was born with many of the deficits or if most were caused by the deprivation he experienced in the first few years of this life. He receives services through Alta Regional as well as mental health. The adoptive mother states she receives in-home behavioral modification support from Alta Regional.

b) *Adequacy of capacity to provide service*. This is a case in which there is a need for multi-agency coordination. The child appears to be at risk of requiring a higher level of care based on his needs. The child's teachers report that the child has many difficulties in the classroom. He does not follow directions, will not stay in his seat, sometimes falls off his chair, hits his peers and takes the belongings of others without permission. The school staff must often redirect him but he does not appear to understand the direction. He is attending school and is placed in Special Education. Peers do not like to play with him at school because he is aggressive toward them.

c) *Accountability.* There was coordination in the case as evidenced by the review team notes in the file. There has been service and placement coordination for the client and his family. The Department of Children and Family has reportedly been less involved in the case since the child was adopted and placed in a permanent family.

d) *Evidence that TBS or other services are working.* The child has made some progress but he continues to have many needs. The adoptive mother said she has not heard of TBS but she said it sounded like a service offered by Regional Center. The overall efficacy of the services was difficult to access due to young age of the child and the large portion of the services that appear to be provided through Regional Center.

e) *Quality of TBS, if TBS was provided.* The child has not received TBS.

f) *Appropriateness of services to kids placed out of county (if applicable).*
The child is not placed outside of the County. The child's services are arranged and coordinated through East Valley Regional Center and the MHP.

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #17

Case Review Team: Eddie Gabriel

Facts: The information on this client was gathered from the review of the child's chart, and interviews with the client, mother, and a previous outpatient therapist. The client is a fifteen-year-old African-American female. She has not received TBS. She is currently in Juvenile Hall. The client was hospitalized in June 2004 with suicidal ideation. Upon discharge she received outpatient treatment. She was initially diagnosed with other depressive disorder, no other symptoms, rule-out bipolar and post-traumatic stress disorder. This was changed to bipolar, no other symptoms in November 2004 by a psychiatrist. She was prescribed Depakote and Prozac. The latter was changed to Zoloft, and then to Abilify.

The client has a history of violence and aggression both at school and home. She has had physical and verbal fights with her older brother, as well as conflicts with her mother over the care of her child (the mother has legal custody). The client was pregnant at age twelve and was living with her baby, mother, and brother. Her history also includes sex work and running away. This includes numerous incidents of the LA Department of Social Services Department of Child and Family, and Juvenile Justice System involvement.

Summary: The client is currently in Juvenile Hall. It is not known when she will be released or to where. Previously to be placed in Juvenile Hall, the client appeared to be progressing well. Both the mother and previous therapist stated that if she stayed on her medications, the client would do well.

Conclusions:

a) Adequacy of access to services, including TBS. It appears that that services the client received prior to her placement in Juvenile Hall were responsive to her needs.

b) Adequacy of capacity to provide service. Due to the client's current status, this is unknown.

c) Accountability. The mother and previous outpatient therapist seem to agree that if the client stayed with the program before her placement in Juvenile Hall she would have done well. Both stated as long as she continued with her medication regime she would have been fine.

d) Evidence that TBS or other services are working. The client is not currently receiving services directly from the mental health plan due to her placement in Juvenile Hall.

e) Quality of TBS, if TBS was provided. The client has not received TBS.

f) Appropriateness of services to kids placed out of county, if applicable). The client is not placed out of county.

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #18

Case Review Team: Rose Lira

Facts: This is a 16-year-old (DOB 08/29/1989) black female, who came to the attention of LAMHP for Specialty Mental Health Services after she made a serious suicidal attempt (ingestion of more than 50 tablets of Ibuprofen 3/14/2003) and her mother requested services for her. She was living at home with her mother, and twin sister. She was given individual therapy through a contract provider of the MHP. She continued to be admitted to various Acute Psychiatric Hospital inpatient units where she was admitted some 9 times with placement in Foster Care. The most recent diagnosis was Axis I Major Depression with psychotic features. Axis II & Axis III-deferred. Axis IV physical harm. Axis V current GAF 50. She was placed in a Community Treatment Facility and they requested both Intensive Day Treatment and TBS to augment her out of home placement. The first session of TBS was authorized 4/12/2004-5/11/2004 for 60 hours in 30 days as her placement was in jeopardy. By November 2004 she was placed at Metropolitan State Hospital. She is receiving Prozac and Zyprexa but reports feeling very tired and having frequent headaches. She (client) has plans to return to live at home with her family there is not any written plan for the use of TBS for the transition the exact date is uncertain. She is in a non-public school and reports doing well. Her family visits are few due to her mother's work schedule and she reports the visits as "going well".

Summary: Mother, Client, and DCF worker were interviewed. Both client and her Mother agreed that she was not able to avail herself of the intervention provided by TBS because she was too far into her self- destructive mode.

Conclusions:

s) Access to Specialty Mental health services was available but mainly to individual therapy. TBS was requested when the client ended up in a higher level of care RCL 14 and CTF and not while living at home with her family struggling to deal with her.

t) The same residential facility where she was placed was a contract provider of TBS for the MHP and she was approved for Intensive Day Treatment and TBS. Client reported feeling that at the time TBS was instituted she was not ready to participate in the therapy and did not benefit from the intense service.

u) Accountability is demonstrated through progress notes and additional information, which is requested by the MHP when services are requested for authorization and again upon re-authorization of services.

v) For this child the TBS services were added while in a higher level of out of home placement and she felt it was not helpful because there were too many services being "thrown at me" that she was unable to benefit.

w) Quality of TBS from the notes appeared adequate.

x) N/A

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review # 19

Case Review Team: Eddie Gabriel

Facts: The information on this client was gathered from the child's chart and interviews with the client, aunt, and mother. The review team was unable to interview the client's therapist. The client is a fifteen- year-old Hispanic male. He was authorized for TBS services in March 2004, but was shortly terminated due to hospitalization and agreement of TBS team that the benchmarks were not reached, and appeared to be not attainable. The client is currently placed in a Community Treatment Facility.

The client has several diagnoses: depressive disorder, on other symptoms; psychotic disorder, no other symptoms; and, post-traumatic stress disorder. His medications include Risperdal, Lexapro, Lithium and Abilify. The client's behavioral problems include suicidal ideation, self-injurious behavior, and aggressive and assaultive behavior. He has been in the Juvenile Justice System since November 2004. He is known to have gang affiliation, and has a long history of legal and psychiatric problems dating back to September 2003. He also assaulted his mother in November 2003

Summary: Unknown since interviews conducted were only with the client and family members.

Conclusions:

a) Adequacy of access to services, including TBS. He was authorized for TBS services in March 2004, but was shortly terminated due to hospitalization and agreement of TBS team that the benchmarks were not reached, and appeared to be not attainable.

b) Adequacy of capacity to provide service. The client was authorized for and received services upon request.

c) Accountability. The LAMHP reviews progress notes to ensure accountability.

d) Evidence that TBS or other services are working. He was authorized for TBS services in March 2004, but was shortly terminated due to hospitalization and agreement of TBS team that the benchmarks were not reached, and appeared to be not attainable. .

e) Quality of TBS, if TBS was provided. TBS was authorized, but was shortly terminated thereafter because of the lack of success.

f) Appropriateness of services to kids placed out of county, if applicable). The client is not placed out of county.

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #20

Case Reviewer: Kathryn Riggs, LCSW

Facts:
The information for this child was gathered from the review of the child's chart, interviews with the client's TBS provider and DCFS worker. Client is a 15-year-old, Latino male. He has received TBS services in the past, presently lives in a level 14 Treatment Facility and is not receiving TBS services. The state hospital evaluated him for the appropriateness for TBS services and determined that the client would not benefit from TBS due to he is not considered appropriate for a transition to a lower level of care. There is disagreement amongst the stakeholders as to the capacity of this minor.

The client has been in the system since 1996 when, age 4, his parents split, chart reveals a history of domestic violence, and drug abuse, he was removed from the home and placed with a foster family. As of August of 2005 he has had 18 "out of home" placements, 6 psychiatric hospitalizations, 4 arrest ending up in juvenile hall. One report revealed 31 DMH episodes, including crisis intervention, and shelter placements. He has been a difficult placement due to his angry outbursts, suicidal ideation, sexually acting out, and poor impulse control. The chart reveals a diagnosis:

Diagnosis:

Axis I: Mood Disorder NOS, Conduct Disorder manifested by sexually inappropriate behaviors, R/O Bipolar, R/O PTSD, R/O ADHD.
Axis II: Borderline Personality Disorder
Axis III: Seizure Disorder
Axis IV: Problems w/ legal system, Hx of physical/sexual abuse, multiple placements
Axis V: 25

Medications: Seroquel, Risperdol, Depakate, Keppra, Hx of Paxil and Clonadine.

Summary: The client's DCFS worker and former TBS worker were informed of the case. TBS has been authorized and successful prior to this last hospital admission. TBS coach reported that the client was making positive changes in behavior, improving coping skills and insight. This was evidenced by he was awarded an Art Scholarship at the Pasadena Art School which really "empowered him." The GLBT group home was appropriate due to the focus of sexual orientation issues, which was addressing his sexually acting out behaviors. Unfortunately his peers at his placement group home, jumped him, and staff was unable to keep his safe. Clients' DCFS worker and TBS coach together advocated for funds to provide 1:1 supervision and got him transferred

to yet another placement. His "chart made him appear worse than he was" TBS coach reported, he has been "stigmatized" due to his history, prior conviction of sexually exposing himself in public and inappropriate comments/advances to a prior individual female counselor. Unfortunately, this new group home was closed a few months later, and this client ended up in a level 14, state hospital, due lacking of placement availability and denied TBS services.

Conclusions:

s) *Adequacy of access to services, including TBS*. Presently client is in a state hospital where services have been considered, 5/24/05, DMH liaison's findings resulted in a denial of TBS; "client issues not resolved, not appropriate for lower level of care, nor in transition.

t) *Adequacy of capacity to provide services.* It appears that the client has received excellent TBS services. Presently there is no plan to provide TBS, however, this writer provided DCFS worker with the phone number of the former TBS worker with the intent of moving this client to a lower level of care when a space becomes available. Last review for a change in placement, they concluded that "he doesn't fit in society", per DCFS worker.

u) *Accountability.* There is limited of family involvement, he has contact with Mom, and is not allowed to speak with father. There was a family reunification effort in October 2003, which failed due him attacking his mother, setting two fires, and masturbating in from of his family.

v) *Evidence that TBS or other services are working.* Client received TBS, extensive therapy, medication throughout program, which was a referral through the probation department.

w) *Quality of TBS, if TBS was provided.* TBS specialist was very knowledgeable and committed with 20 years experience in the field. As reported above, TBS was successful and working for this case. Prior to this "he had participated in many sexual offender classes in many placement which had failed," TBS reported.

x) *Appropriateness of services to kids placed out of county, if applicable.)* NA

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Case Review #21

Case Review Team: Anne Murray, LCSW

Facts: The information on this child was gathered from the review of the child's chart(s) and interviews with the client, the social worker from her current placement, the therapist from her previous group home and the client's biological mother. The client is a 17-year-old Hispanic female residing in a RCL 12 group home. She has received TBS in the past and she was recently referred and approved for TBS at her current placement. TBS had not started at the time of the focused review. This is the fourth authorization and this most recent request was submitted on July 2, 2004. This is a case in which there has been multi-agency involvement by probation, the Department of Children and Family Services (DCFS) and the county department of mental health.

The chart included a number of DSM diagnoses for the client: bipolar disorder not otherwise specified depression, traits of borderline personality disorder and oppositional defiant disorder. The client has a number of behaviors that cause problems in her living situation and in the school classroom. She has trouble sleeping, drug use, excessive worry, and fears of being rejected, risk-taking behavior, poor boundaries and impulsiveness that sometimes puts her in physical danger. She has a history of becoming very assaultive and self-injurious. The documentation indicates that she has taken lithium and Zyprexa.

Summary: The child has been very troubled from an early age. She was kicked out of pre-school for hitting other children. She is severely emotionally disturbed (SED) and a current IEP was located in the client's chart. The client has primarily attended on-site, non-public schools at her residential placements. A psychiatric evaluation completed by an MD in 2002 reported a poor prognosis for the child. The client has had multiple placements in residential treatment, juvenile hall, acute inpatient hospitals and Metropolitan State Hospital. The client's charts indicate there have been at least fifteen hospitalizations, five of them due to suicide attempts.

The therapist reported that the client is very bright and engaging. She has the capacity to be insightful about her internal processes and was able to do some very good work while in individual and family therapy. The client's mother is very supportive of her but she could no longer have her in the home due to her daughter's dangerous behavior and the risk the client posed for her younger sister. The child's mother complained of some issues with the department of probation. She said her daughter has been assigned to four different probation

officers and they are often difficult to reach. Juvenile probation is garnishing the mother's wages to assist in the cost of the child's group home placement.

Conclusions:

a) *Adequacy of access to services, including TBS.* The client's mother was very disappointed when her daughter's behavior resulted in the youth having to be placed on probation. This now results in juvenile probation being the lead in the case and making the placement decisions for the client. The mother of the client has also been unhappy that her daughter had to be removed from her previous placement. The client was apparently doing very well at Starview Adolescent Treatment Center in Torrence, CA. and she had made a very good connection with her therapist. The client and all of the other children who were placed there by juvenile probation were forced to move out of Starview and placed in other facilities. The child is now in a RCL 12 and she tends to go AWOL because there is not as much structure as in the previous RCL 14 group home. The clinician at Starview believed the child was making excellent progress there. The mother is also displeased that the RCL 12 is further from her home making it much more difficult to visit her daughter.

b) *Adequacy of capacity to provide service.* The county MHP has a good capacity to provide services to children. There do not appear to be significant barriers to children receiving TBS or other children's mental health services in Los Angeles County. The client received many mental health services particularly while in residential treatment. The services included day treatment-intensive, individual and family therapy, medication, independent living, and dialectic behavioral therapy.

c) *Accountability.* There was evidence of coordination in the case as described in the interviews and documentation of such in the client's file. The therapist was very familiar with the client and with the other components of the client's care and treatment. The coordination of the mental health services may present many challenges now that probation has become the "parent" and lead in the case.

d) *Evidence that TBS or other services are working.* It is hoped that she will be able to turn things around and be placed in a lower level of care in the future. The client was placed in an out-of-state group home through AB3632. The placement was not as successful as hoped. The child's symptoms worsened during this time and she had to be placed in Metropolitan State Hospital when she was returned to California.

e) *Quality of TBS, if TBS was provided.* The client has received TBS. The two therapists interviewed during the review were both very familiar with TBS. The

child's mother reported that TBS is a valued service and she wants her daughter to receive this service again. The service apparently did have a positive affect.

f) *Appropriateness of services to kids placed out of county (if applicable).*
The child is not placed outside the county.

Appendix 2 – External Stakeholder Focus Group Analysis

DMH Focused Review of services to Emily Q. Class Members

Los Angeles County Department of Mental Health

Dates of review: July 25 – July 29, 2005

Focus Group Facilitators: Troy Konarski, DMH County Operations
Ivor Groves, PhD, Special Master Emily Q

The Qualitative Focused Review consisted of 6 Focus Groups performed on July 26- July 28, 2005 and interviews. The external stakeholder focus groups for Los Angeles County Mental Health Plan (MHP) included TBS coaches, Contracted Providers (Group Homes), Parent Partners, Clients, LADMH administrative staff and LA County Auditor staff.

Another major issue discussed during the focus groups was providing sufficient number of TBS providers in such a large area and number of class members throughout the entire county. The number of TBS contracts for Los Angeles County is 23.

The focus groups agreed that Los Angeles County has an adequate referral process; however, the referral process was described as complex and not standardized. Providers report this could cause delays in providing services to class members. One member of the focus groups explained, "When making a referral for TBS, it depends on who you get and the county staff can request additional information that will slow down our ability to provide TBS. We usually start a week in advance in getting the referral in and many times we are delayed because of county staff requesting additional information and we have lost a couple of days of services."

The MHP is using TBS to maintain children and youth in a lower level of residential care and to prevent them from needing a higher level of care. From the cases that the DMH team reviewed. TBS is used to transition class members to a lower level of care; however, less frequently than it used to maintain a lower level of care.

Attachment A –

Data Reports

LOS ANGELES County

Therapeutic Behavioral Services (TBS)
Notifications Quarterly Summary

The TBS notification form indicates the provision of TBS to a beneficiary. Analysis is below.

Data Collection period: **Sep.– Dec. 2004**

Total # of TBS Notification forms: **328 unduplicated clients (360 notifications received)**

Initial Information – Class Membership
**293 forms; can have more than one response per form; 67 forms were quarterly updates which do not ask this question*

124 - In Rate Classification Level (RCL) 12 or above

114 - Being considered for RCL 12 or above

72 - One psychiatric hospitalization in preceding 24 months

8 - Previously received TBS while Class Member and otherwise would not be eligible

Gender

208 Boys 120 Female

Age

320 ages 0-17 8 age 18-20

Ethnicity

205 White 46 African-American 62 Hispanic

0 Native American 2 Asian/PacificIslander 13 Other

Primary residence for child/youth while receiving TBS as indicated on notification forms: (8 in RCL lower than 12)

127 Family Home 45 Foster Home 1 Foster Family Agency

0 Children's Shelter 184 Group Home 2 CTF

Therapeutic Behavioral Services (TBS)
Notifications Quarterly Summary

6 Other	**141** (RCL 12) **35** (RCL 14)

Service Need:

324	- To prevent placement in higher level of care	**37**	- To enable transition to a lower level of care

Analysis (Identify trends, questions, etc.) ____________________________

Therapeutic Behavioral Services (TBS)
Certification Quarterly Summary

The TBS certification form indicates that TBS was considered for a beneficiary but not provided. Analysis of the data reported to DMH will focus on identifying trends in the denial of TBS as reported on the TBS certification forms. Analysis is below.

Data Collection period: **September – December 2004**

Total # of TBS Certification forms: **110**

0	-TBS has been provided and the placement is still required. *Why? Did the services fail (e.g. timeliness in providing TBS, duration/frequency of TBS services) Were client symptoms too acute to be treated by TBS? Who makes this decision?*

TBS has been considered and has been determined inappropriate because:

0	-TBS services will not resolve the child/youth's transition issues or prevent the child/youth from moving to a higher level of care. *Who makes this determination?*

0	-The child/youth/family refuses to participate in the full range of services specified in the treatment plan as necessary to address the child/youth's mental illness. *Cultural issues? Involvement in the planning process?*

0	TBS is appropriate but: # ___ - Was refused by family/caregiver or the child/youth (when appropriate). *Cultural issues? Involvement in the planning process?*

0	# ___ -Is not available because…other *What criteria was used in this decision?*

Therapeutic Behavioral Services (TBS)
Certification Quarterly Summary

Analysis (Identify trends, questions, etc.) ________________

Therapeutic Behavioral Services (TBS)
4th Authorizations Quarterly Summary

MHPs are required to submit a 4th authorization letter to the Department of Mental Health (DMH) upon a 4th TBS authorization approval. Analysis of this data will focus on identifying those circumstances that warrant authorizations beyond the established authorization timelines and reported in the 4th authorization letters.

Data Collection Period: Sep. – Dec. 2004

Total # of TBS 4th Authorization Letters: 43

Summary of circumstances that warrant authorizations beyond established timelines:

Preliminary Analysis:

Therapeutic Behavioral Services (TBS)
Notice of Action Quarterly Summary

MHPs are required to submit copies of Notices of Action issued to beneficiaries when the MHP denies an MHP payment authorization for TBS. The preliminary analysis of this data will focus on identifying the reasons the MHP payment authorizations were denied. The analysis may indicate the need to focus on specific issues in the review of the MHP's authorization system.

Data Collection Period: Sep. – Dec. 2004

Total # of Notices of Action: 0

Summary of reasons for issuance of Notices of Action:

Preliminary Analysis:

CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-3535

June 10, 2005

Mr. Marvin Southard, DSW
Mental Health Director
Los Angeles County Mental Health Department
550 S. Vermont Avenue
Los Angeles, CA 90020

Dear Dr. Southard:

RESPONSE TO EXTEND PREPARATION TIME FOR THE QUALITATIVE REVIEW OF SERVICES TO EMAILY Q. V.BONTA CLASS MEMBERS IN LOS ANGELES COUNTY

On June 8, 2005, the Department of Mental Health (DMH) received your request for an extension of the preparation time for the TBS Review scheduled for Monday, June 13-17, 2005 in Los Angeles County. Upon review by DMH and the decision of the Special Master to be unavailable for the review, DMH has granted your request to extend the preparation time for your review.

DMH will re-schedule the review with the Special Master during the week of June 13th. Please inform all scheduled appointments of the latest developments and request their participation for the re-scheduled review. DMH will notify you as soon as a new schedule is established, and will work with your staff in establishing the final schedule of the review.

Thank you for your patience in this process. If you have any questions, please contact Eddie Gabriel at (916) 654-3263, or Troy Konarski at (916) 654-2643.

Sincerely,

JOHN LESSLEY
Chief, County Operations, South

cc:
TBS Focus Review Team at DMH
Dr. Ivor Groves, Special Master
Rita McCabe, DMH
Mateo Munoz, Attorney General
Michael Borunda, DMH
Melinda Bird, PAI

Attachment B –
Preliminary Analysis

Focused Review for Services to Emily Q. Class Member
Preliminary Analysis Summary

DATA SUMMARY

Open TBS Cases (as reported by the county) – ;
TBS Notifications – 360 –
TBS Certifications – 110
TBS NOAs – 0
TBS 4th Authorizations – 43

RCL Rate - -3.78   Readmit Rate - -7.07   SH Rate – -4.57

Los Angeles county TBS coordinator participates on multi-agency assessment teams with juvenile justice, social services, schools, public health, and EPSDT providers. There appears to be a well-coordinated system for interagency collaboration, increasing awareness and access to TBS.

Los Angeles county has an authorization set up such that all initial requests for assessment for TBS are approved via the TBS Coordinator.

Subsequent re-authorization requests are also approved (or denied) by the TBS Coordinator; to date zero requests for re-authorization have been denied. In the past year 43 authorization requests were received but it is unclear from the information available from whom these requests originated.

Los Angeles county has established weekly and monthly methods for monitoring TBS when it is provided.

Los Angeles county has established mechanisms for outreach and education to agencies and families regarding the availability of TBS as well as information about the referral.

Information provided regarding the 7.07% decrease in re-hospitalization focused on children's services and decreased the re-hospitalization rate.

Coordination of the TBS treatment plan clearly involves participation of the behavior team and support counselor.

The review team has additional questions around the following:

1. Question 5 – What time period does the number of initial TBS authorization request that have been certified to meet eligibility, class, or

Focused Review for Services to Emily Q. Class Member
Preliminary Analysis Summary

need criteria cover? Also how many Department of Probation children/youth how encountered this problem.

2. Question 12 – How frequently does the PEQIC meet?
3. Question 15 – How is the communication between the TBS coach/aide a clinician achieved for the single provider who is not contracted also deliver specialty mental health services achieved?
4. Question 16?

Attachment C –

Qualitative Focused Review Protocol

FOCUSED REVIEW OF SERVICES TO EMILY Q. CLASS MEMBERS
Los Angeles County MHP PRE-VISIT QUESTIONNAIRE

1. *Who is responsible for coordinating TBS in your MHP? Does this person have other responsibilities outside of TBS?*

The clinical and program elements of TBS are coordinated by Terri D. Boykins, L.C.S.W. Mental Health Clinical Program Manager under the direction of Paul McIver, L.C.S.W. Mental Health Clinical District Chief. In addition to TBS, Ms. Boykins manages the Level 12 Group Homes and TBS Unit. This Unit plans, develops, and monitors an array of Specialty Mental Health Services (DTI, DR, MHS, TCM, MS, CI) in RCL-12 and higher level programs and other specialized program settings throughout Los Angeles County including a program in both Santa Barbara and Orange Counties.

All aspects of the authorization (pre-, re-) process for TBS are coordinated by Pansy Washington, M.S, Mental Health Program Manager, under the direction of Toni DelliQuadri, M.S.W., M.P.A., Deputy Director Bureau of Standards, Practices, and Conduct. In addition to TBS authorization, Ms. Washington manages the Medi-Cal Professional Services Division (includes Fee-For-Service, Managed Care, Phase II Consolidation, Psychological Testing Authorization, Day Treatment Authorization).

2. *How are TBS authorized in your MHP? (Be sure to explain the authorization processes for initial requests, reauthorization requests, and approval.)*

The Central Authorization Unit (CAU), along with the Chief Information Office Bureau (CIOB), has developed a secured Internet-based system to facilitate the payment authorization process. This system is connected to the Department's Management Information System (MIS) and Integrated System (IS) and prohibits unauthorized units of service for TBS from being entered into the systems. Providers are required to enter Client Care Plans (CCPs) into the system to initiate the payment authorization process.

INITIAL AUTHORIZATION

A TBS Provider receives a referral for services. The TBS Provider accesses the secured TBS/Day Treatment website, and submits an authorization request to the CAU by completing a CCP for TBS services. This is accomplished by completing a CCP and the TBS Assessment (if requesting 60 days). The Provider may create the CCP, save it, and retrieve it later for modification and/or completion prior to submitting to the CAU.
The CCP contains the following elements:

- Targeted behaviors or symptoms
- A baseline for the frequency of the behaviors
- A goal to determine the change in behaviors
- Intervention(s) proposed to replace the negative behavior with positive behavior
- Caregiver transitional skills

When the authorization is saved for the first time, a unique authorization number is generated. The status of the request is "pending DMH decision." The Provider can retrieve the CCP by searching using any of the following criteria:

- Authorization number
- Management Information System (MIS) number
- Service type
- Client current status

* Currently in Day Treatment
* Hospitalized
* Currently in Jail/Juvenile hall

* Currently receiving Mental Health Services at a Clinic
* None of the above
* In danger of losing Placement/Housing
* Recently released from Jail/Juvenile Hall
* Currently receiving TBS services
- Authorization status
* Pending DMH Decision
* Pending Additional Provider Information
* Void

The CAU can retrieve the CCP using the following criteria:

- Authorization number
- MIS number
- Provider number (reporting unit of agency)
- Client current status
- Service Type
- Authorization status

To submit an authorization request to the CAU, the Provider must save the CCP and check the "submit to DMH" box. Once the request is submitted to the CAU, the following steps are taken:

- Each day, the system generates hourly real-time reports of all the authorization requests submitted by providers.
- The CAU support staff retrieves and prints the requests.
- CAU support staff will create a client chart, which includes the Client Care Plan, TBS Assessment, if available, and screens from the MIS/IS and Medi-Cal Eligibility. The CAU turnaround time to review the plan and authorize an initial payment request is 7 days, unless an Expedited Review is requested (see below).
- The client chart is distributed to the clinical reviewers. For the purpose of continuity and consistency, it is CAU policy that whenever possible, the same reviewer continues with the same client throughout the client's authorization periods.
- The reviewer uses a checklist to review the CCP and assessment. If the reviewer requests additional documentation/clarification, it is requested by writing a note in the "communication between DMH and Provider" section on the CCP. The status is then changed to "pending additional provider information." If the Provider has registered an email address in the system, an email is automatically generated to the Provider to check the authorization for the additional requested information. After the Provider complies with the request, the status is changed back to "pending DMH decision." An email is automatically generated by the system to the reviewer to check the CCP for the requested changes. (In the event the Provider has not registered an email address on the automated authorization system, it becomes the Provider's responsibility to establish a tickler system to facilitate timely responses to the CAU request).
  The reviewers regularly check the website for CCPs that have been changed from the status of "pending additional provider information" back to "pending DMH decision" whether or not an email has informed them of the change.

If the documentation is sufficient, the CCP is authorized for 30 days, unless the CCP is accompanied by a TBS assessment (which is completed online) and is authorized for 60 days. In the event the CCP is authorized for 30 days, the assessment is completed and services are initiated.

REAUTHORIZATION

When appropriate, the Provider submits a request for reauthorization, which includes the TBS assessment and a new CCP. The outcome progress section of the previous CCP is completed when submitting a reauthorization request. If this section is incomplete, the CAU notifies the providers to complete this section in order for the review process to continue. The turn around time for a reauthorization is 7 days unless a Provider submits an Expedited Request, which means the Provider certifies that the client meets one of three criteria:

- That without TBS a client is likely to need a higher level of care within the next 14 days
- Be unable to transition to a lower level of care without TBS in the next 14 days; or
- That the current authorization will expire in 14 days or less resulting in a gap in services.

An Expedited Request is processed with a response to the Provider within three business days. In order to certify that an Expedited Request is necessary, the Provider must have an electronic signature on file with the Department. This is accomplished by the Provider submitting an *Electronic Signature Agreement for Clinician Requesting Expedited Review Request for Therapeutic Behavioral Services* form. The form may be accessed and printed from a link in the signature section of a TBS CCP. The form must be signed by the clinician and Executive Director, Head of Service or Program Manager of the agency. The form is sent to the CAU where a copy is filed and original sent to the Chief Information Office Bureau (CIOB) to add to the list of clinicians approved to submit Expedited requests.

The targeted behavioral goals must be quantified with a numerical baseline and goal. For example, "Client will reduce "x" behavior from "y" times per day to "z" times per day by utilizing replacement behaviors, which should be specifically identified". If this is a 60-day authorization request, a transitional plan is required and must include timelines and benchmarks.

The Provider can access the CCP and the assessment, located in the online system, at anytime. Changes may be made anytime prior to the authorization being approved or denied. To check the status of the authorization, view the "authorization status" located on the *Authorization Search* page of the website. A CCP may have any of the following statuses:

- Pending DMH decision
- Pending additional Provider information
- Approved
- Denied (NOA-B)
- Modified approval (NOA-B)
- Pending modified approval (Consult with supervisor)
- Pending denial (Consult with supervisor)
- Void

Once the CCP is approved, the client may receive services and the Provider is able to bill for services by entering units of service into the IS. Providers will not be reimbursed when prepayment authorization has not been approved by the CAU. If no authorization is in the system for the days entered, the claim will be denied. If the authorization request is denied or modified, a Notice of Action (NOA) is sent to the client, the Provider and Los Angeles County Department of Mental Health Patients Rights Office.

REPORTS

The CAU and the CIOB have developed a number of reports to enhance Provider efficiency:

* Productivity Reports
* Monthly CAU Activity vs. Your Organization (Provides the ratio of CAU total activity to specific agency activity)
* Staff Productivity (By provider, by staff)
* Planning Reports
* Authorizations Coming Up for Renewal
* Authorized Days and Hours Remaining in CCPs
* Unsubmitted CCPs

Utilization Reports

* CCP Matrix (history of services by client)
* Discharged Client Utilization (clients discharge date per provider)
* Unique Client Counts: Monthly

Audit Trail Reports

* CCP Audit Trail (Tracks modification of a CCP)
* Notes and Provider Communications (Allows the provider to view and print all the notes and communications between agency staff and the CAU of each CCP)

3. *In the past year, how many initial TBS authorization requests have been* ***received****?*

In the past **calendar year** 1/1/04 thru 12/31/04, the Central Authorization Unit (CAU) received **938** initial TBS authorization requests.
For **fiscal year** 7/1/2004 thru 5/18/05, the CAU received **738** initial TBS authorization requests.

4. *In the past year, how many initial TBS authorization requests have been* ***approved****?*

Of the 938 initial authorizations received for the **calendar year** 2004, the CAU approved **928** initial requests.
The CAU approved **730** of the 738 initial authorizations received for **fiscal year** 7/1/2004 through 5/18/05.

5. In the past year, how many initial TBS authorization requests have been certified to not meet the eligibility, class, or need criteria?
   0 did not meet the eligibility criteria
   4 did not meet the class criteria
   3 did not meet the need criteria

Note: The CAU has encountered a problem with requests for TBS payment authorization for the Department of Probation children/youth, who are released from Juvenile Hall into residential placements. The child/youth is not eligible for Medi-Cal while in a Juvenile Hall placement. Therefore, Medi-Cal needs to be reinstated when sent to their new placement. Until Medi-Cal is reinstated, the child/youth is ineligible for Medi-Cal benefits, thus disqualifying the child/youth for receiving TBS.

6. How are your TBS providers trained/educated regarding the principles and practices of TBS in your MHP?

TBS providers are trained/educated regarding principles and practices of TBS through a combination of the following:

- Monthly/Bi-monthly provider meetings
- State DMH Letters and Information Notices
- Monthly CIMH Administrative Conference Calls.
- LAC-DMH Contract Service Exhibits
- LAC-DMH Medi-Cal Rehabilitation Manual
- TBS Request for Information
- LAC-DMH Plan for TBS Implementation
- CIMH Provided on-site training in 2003
- Designated LAC-DMH TBS contact staff
- On-site program monitoring by designated LAC-DMH TBS Unit staff
- LAC-DMH Program Review Division Documentation Training

7. At what level of participation have other county agencies been educated about the principles and practices of TBS in your MHP? (Identify those agencies in which training has been provided, including frequency).

LAC-DMH has made formal and informal presentations related to access, availability, eligibility, description, and target population of TBS to the Department of Children and Family Services (Child Welfare), Probation, directly-operated clinics, and contracted mental health provider agencies. Due to very limited resources, presentations are made on a requested basis. Additionally, the LAC-DMH 24-hour ACCESS center is always available to disseminate information on locating providers of TBS.

8. What community outreach has been done for clients and family members regarding the availability of TBS as a specialty mental health service? Was outreach done to non-English speaking communities?

Community outreach has been attempted through formal and informal information (both written and verbal) provided to parents/caregivers and other interested stakeholders regarding the availability of TBS. Outreach is generally provided at those locations and points-of-service where other specialty mental health services are available.

When reviewing authorization requests for Day Treatment or additional mental health services for clients concurrently in Day Treatment, the CAU staff has recommended that providers consider TBS for the client.

Outreach activities have been provided in English, Spanish, and other target languages reflective of the different ethnic communities of the County.

9. Do you have any TBS providers that have the capability to provide TBS in a language other than English? Has there been a need for non-English speaking providers for TBS?

LAC TBS Providers are staffed to deliver services to consumers in the following languages:

- American Sign Language (ASL)
- Spanish
- Russian
- Korean
- Vietnamese

10. Has a grievance (or formerly complaint) ever been received regarding access to a TBS, or from a TBS provider? If so, please summarize the nature of the complaint(s) and resolution(s).

AUTHORIZATION NUMBER	DATE OF NOA	REASON FOR NOA	FIRST LEVEL APPEAL/OUTCOME	SECOND LEVEL APPEAL/OUTCOME
23609	7/23/04	Per State DMH letter 99-03, TBS not reimbursable for children/youth who never will be able to sustain non-impulsive self directed behavior and engage in appropriate community activities without full time supervision	8/18/04—Appeal Denied. "Sufficient justification for TBS not demonstrated. Also child not at risk of being moved to higher level of care/out-of home placement".	None
25033	8/24/04	Per State DMH letter 99-03, TBS not intended to ensure safety of self or others or for children/youth who never will be able to sustain non-impulsive self directed behavior and engage in appropriate community activities without full time supervision.	9/4/04—Appeal Denied "Sufficient justification for TBS not demonstrated. TBS did not appear to be producing demonstrable positive benefit for minor.	None
27936	10/22/04	Does not meet criteria for TBS per State DMH letter 99-03.	11/17/04—Appeal Denied "Does not appear to be producing demonstrable positive benefit. The Clinical Management Review Committee agreed that individual needed ongoing mental health services but recommended a thorough review be done of diagnosis, treatment plan and psychotropic medication regimen".	None
33856	2/15/05	Per State DMH letter 99-03, TBS not reimbursable for children/youth who never will be able to sustain non-impulsive self directed behavior and engage in appropriate community activities without full time supervision. Per DMH Psychological testing, client's IQ has deteriorated significantly over the last 5 years	3/5/05—Appeal Denied "Sufficient justification for TBS not demonstrated. TBS did not appear to be producing demonstrable positive benefit for minor".	5/10/05 – Second Level Appeal received 5/12/05—Second Level Appeal Denied. No evidence that TBS have lessened this child's need for further intensive services during the extensive time that TBS was provided. No evidence of significant improvement in this child's behavioral symptoms or the functional level during the same time period.

11. How are clients and family members involved in the treatment planning of TBS?

LAC-DMH delivers specialty mental health services, including TBS, using coordinated care principles. Therefore, all services assessment and planning is developed with the participation and input of client and parent/caretaker and continues throughout the treatment process. Additionally, all TBS providers convene periodic interagency planning meetings which may include client, parent/caretaker, clinicians, and any other entities that client/parent feel may be helpful in planning for services.

12. How does your county include TBS in its quality improvement efforts?

TBS is included in the Quality Improvement activities within LAC-DMH. LAC-DMH TBS Unit convenes a quarterly TBS-Providers Meeting where training, discussion, and TBS updated information is disseminated. In the near future, TBS will be included in the Provider Executive Quality Improvement Committee (PEQIC).

13. What is the county MHP's process for ensuring transition age youth (TAY) in foster care are assessed for TBS?

13.a-c. LAC-DMH does not currently have a separate process for ensuring TAY, TAY in foster care, or TAY with multiple hospitalizations are assessed for TBS. Instead, all youth 0-21 years of age are afforded requested TBS assessment and services to the extent that resources are available.

13.d. Specifically, what is the process for ensuring TAY placed in CTFs, IMDs, or State Hospitals are assessed for TBS?

TBS Certification is completed at Interagency (LAC-DMH, DCFS, Probation, CTF, Metro State Hospital-MSH, Level-14) Screening and Placement Committee meetings, held weekly. The certification occurs prior to admission to CTFs, IMDs, MSH). TBS assessment for clients of MSH is completed quarterly. Records are kept on file.

14. Has the MHP authorized TBS for children placed out of county? If so, for how many children?

Yes, LAC-DMH routinely receives and authorizes TBS services requests for children placed out of county. To date, 31 unique clients have been authorized. Total out-of-county authorizations since July 2003 is 74.

15. An essential component to TBS is the communication between the TBS coach/aide and the clinician. How is this achieved in your system? If the process varies by TBS provider, please identify the different methods of integrations for a representative number of providers.

Communication and dissemination between the TBS coach/specialist and the clinician is a vital component of service delivery. Twenty-two of 23 LAC-DMH TBS providers are also contracted to deliver specialty mental health services. This linkage provides (in-house) clinical treatment resources and communication between TBS coach/team and other members of the client's treatment team.

16. LAC-DMH is unable to reconcile the data provided to our available databases. Any explanation would be based on speculation. We will need additional time to fully evaluate the data provided.